STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G194	A. BUILDING _____ B. WING _____	07/02/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INNOVATIVE LIFE SOLUTIONS, INC	114 DIVISION AVENUE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS A recertification survey was conducted from June 30, 2010 through July 2, 2010. The survey was initiated using the fundamental survey process. A sampling of three clients was selected from a resident population of two men and three women with various degrees of intellectual and/or developmental disabilities. The findings of the survey were based on observations, interviews with clients and staff in the home and at two day programs, as well as a review of client and administrative records, including incident reports.	W 000	Received 7/30/10 GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002	
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure outside services met the needs of one of three clients included in the sample. (Client #3) The finding includes: On June 30, 2010, beginning at 11:34 a.m., Client #3 was observed watching a concert on television at his day program. At 11:50 a.m., he was observed sitting in a different class room with his one to one direct support staff and classmates. Interview with the one to one staff revealed they were waiting for lunch to be served. At 12:21 p.m., Client #3 went into the cafeteria to have lunch.	W 120	W120 ILS will provide training for all staff on Individual 3 Health Maintenance Care Plan. QMRP will provide training to Day Program staff during monthly visit on or before 08/01/2010.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

EXECUTIVE DIRECTOR — 7/30/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G194	A. BUILDING _____ B. WING _____	07/02/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INNOVATIVE LIFE SOLUTIONS, INC	114 DIVISION AVENUE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 120	Continued From page 1 On June 30, 2010, at 2:30 p.m., review of Client #3's physician's order dated, June 1, 2010, revealed an order stating "elevate legs while client is in wheelchair." At no time while at the day program did client #3 have his legs elevated. Interview with the one to one staff on the same day, at 4:40 p.m., confirmed that Client #3 did not elevate his legs while at the day program. The facility failed to ensure that the day program encouraged Client #3 to elevate his legs as prescribed.	W 120		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the Qualified Mental Retardation Professional (QMRP) coordinated, integrated, and monitored services, for two off three clients in the sample. (Clients #1 and #3) The findings include: 1. The facility's QMRP failed to coordinate services with the speech pathologist to ensure staff was effectively trained on how to properly position Client #3's bed as he ate. On June 30, 2010, at 5:15 p.m., Client #3 was observed eating dinner in bed. Subsequent interview with the direct support staff revealed the client refused to eat dinner at the table. Further	W 159	W159 ILS will have Physical Therapist assess Individual #3 for appropriate positioning during meal time. After collaborating with Physical Therapist, Speech and Language consultant will update mealtime protocol to include appropriate positioning for Individual #3. Physical Therapist will provide training for ILS staff on or before 08/03/2010.	

STATEMENT OF DEFICIENCIES AND PLAN DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATIDN NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G194	A. BUILDING _____ B. WING _____	07/02/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INNOVATIVE LIFE SOLUTIONS, INC	114 DIVISION AVENUE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATDRY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CRDSS-REFERENCED TD THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 159	Continued From page 2 observation revealed the head of his bed was partially raised as he ate his dinner. Review of Client #3 's Speech mealtime guidelines dated August 10, 2008, on June 30, 2010, at 7:30 p.m., revealed staff is required to have the client seated in an upright position to the maximum degree possible when eating in bed. Interview with the administrator on July 1, 2010, at 2:50 p.m., indicated that Client #3's bed should not be positioned at the maximum degree while eating in bed. Further interview with the administratDr and the QMRP revealed they will request a comprehensive assessment from the speech pathologist. At the time of the survey, there was no evidence that the QMRP had coordinated with the Interdisciplinary Team (IDT), including the speech pathologist to determine if the previous recommendations in the protocol continued to be appropriate for the client. 2. The facility's QMRP failed to ensure continuous active treatment for Client #2 on her training objective designed to improve her personal management skills (folding of clothing). [See W249] 3. The facility's QMRP failed to coordinate the physical therapy recommendation that Client #3 be provided a headrest for his wheelchair. On June 30, 2010, at 6:31 p.m., review of Client #3's physical therapy wheelchair evaluation form, dated June 16, 2010, revealed a recommendation to install two footrest on the client's wheelchair and a headrest to "support his head". Interview with the house manager (HM) and the QMRP on July 2, 2010, revealed that the client's footrests were ordered, however, the facility's QMRP was	W 159	The QMRP will provide training with staff to ensure individual #2, as well as all individuals served, participate in and receive continuous active treatment on or before 08/03/2010. The QMRP will observe all individuals progress in attaining goals by reviewing data collected every month and documenting this observance in the QMRP Monthly Note. ILS Program Director will provide training with QMRP on the process of implementing recommendations per consultant assessments on or before 08/03/2010. QMRP will document progress in implementing consultant recommendations for all individuals. QMRP will follow up with adaptive equipment vendor regarding headrest for individual #3.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G194	A. BUILDING _____ B. WING _____	07/02/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INNOVATIVE LIFE SOLUTIONS, INC	114 DIVISION AVENUE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 159	Continued From page 3 unaware of the recommendation for a headrest.	W 159		
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure staff received effective training to address the needs of the clients, for one of three clients in the sample. (Client #3) The finding includes: The facility failed to ensure staff demonstrated competency in implementing Client #3's diet order, as evidenced below: On June 30, 2010, at 11:49 a.m., Client #3's one to one direct support staff from the facility, informed the day program cafeteria staff of Client #3's dietary order. At 12:24 p.m., Client #3 was observed eating tuna salad, garden salad, and peaches with a built-up handle spoon inside a palm cuff. At 12:28 p.m., the client asked the one to one staff to assist him with picking up his crackers. The one to one staff picked up the whole cracker and placed it on the client's spoon. The client then placed the whole cracker in his mouth, then began to chew the cracker. Review of Client #1's physician orders (POS) dated June 1, 2010, on June 30, 2010, at 2:30 p.m., revealed Client #3 was prescribed a chopped, high fiber, no concentrated sweets diet.	W 189	W189 ILS will have Nutritionist and Speech and Language consultant review and clarify need for special diet texture. QMRP will provide training with staff in residential facility and at day program regarding individual #3 mealtime protocol and documentation of refusal to eat supplements as recommended on or before 08/04/2010.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G194	A. BUILDING _____ B. WING _____	07/02/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INNOVATIVE LIFE SOLUTIONS, INC	114 DIVISION AVENUE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 189	Continued From page 4 Additional review revealed an order for the client to receive a low fat, low calorie yogurt at breakfast and lunch. Interview with the one to one staff on the same day, at 4:40 p.m., confirmed Client #3 did not receive yogurt for lunch. Further interview revealed the client's crackers were not chopped as ordered. There was no evidence that the facility implemented Client #3's diet as ordered.	W 189		
W 192	483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that each staff was provided training on the health needs of one of three clients in the sample. (Client #2) The finding includes: The facility failed to ensure that each staff received updated training on Client #2's protocol for the continuous administration of oxygen, as evidenced below: On June 30, 2010 at 8:58 a.m., Client #2 was observed leaving the facility with portable oxygen infusing via a nasal cannula. Interview with staff at this time revealed the client was going to an appointment and that she must always take her oxygen with her. The review of unusual incidents on June 30, 2010 at 1:40 p.m., revealed on June 21, 2010, Client #2 ran out of oxygen while on her way to an audiology appointment.	W 192	W192 ILS Program Director will provide training with management and nursing staff regarding ensuring all staff participate in mandatory trainings. ILS has modified its Staff Training Policy to state, that any staff not in attendance for individual specific training on scheduled date will make up the training within one week of scheduled date or be removed from residential facility until trained. ILS will ensure all staff working with individual #2 receives training on Oxygen Protocol and Health Maintenance Care Plan on or before 08/04/2010.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G194	A. BUILDING _____ B. WING _____	07/02/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INNOVATIVE LIFE SOLUTIONS, INC	114 DIVISION AVENUE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 192	Continued From page 5 Interview with the van driver on July 2, 2010 at 9:15 a.m., and the van escort at 2:37 p.m., revealed that they checked the gauge on Client #2's oxygen tank on 6/21/10, prior to putting her on the van. Both staff indicated that the gauge was in " the green", which indicated the client still had oxygen in the tank. The driver revealed that the client rode with her and the van escort to drop off her house mate at her day program. They then proceeded to Client #2's audiology appointment at a local hospital clinic. According to both staff, approximately one block from the appointment, the client indicated that she was having breathing difficulty. Upon checking the gauge on the oxygen tank, they noted that the gauge was in "the red", which indicated there was no more oxygen available. After notifying the home for further instructions, an attempt was made by the staff to obtain oxygen from the audiology clinic, however the staff was told there was no oxygen on site. The staff indicated that they then attempted to return to the home to get oxygen as instructed, however a few minutes later, the client stated that her "arm hurt". Emergency Medical Services (EMS) was called, and upon arrival provided oxygen, then transported the client to the emergency room, when she was further assessed. The client was discharged to the group home on the same day in stable condition. On July 2, 2010 at 3:07 p.m., the review of the investigation of the incident revealed it concluded that "the gauge on the oxygen tank used to verify the level of oxygen may have malfunctioned, causing staff and the individual to see a false reading of the amount of available oxygen in the tank." Record review on July 2, 2010 at 3:17 p.m. revealed on 3/4/10, the pulmonologist stated "Patient's oxygen saturation is 68% after only 2	W 192		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G194	A. BUILDING _____ B. WING _____	07/02/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INNOVATIVE LIFE SOLUTIONS, INC	114 DIVISION AVENUE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 192	Continued From page 6 minutes of hallway walking. Provide continuous therapy at all times." Interview with the program director (PD)/Registered Nurse (RN) on July 2, 2010 at 10:15 a.m., revealed the client is now to take a large oxygen tank and also a small oxygen tank with her daily, when leaving the facility. The PD/RN indicated that the pharmacy had started sending the 4 unit oxygen tanks instead of the 6 unit ones previously provided to the client, however, had not informed the home of this change. The PD/RN stated that the agency policy was adjusted to state that the client is to have an additional 2 hour portable oxygen tank when escorted out of the residential facility for any reason. Further review of the agency's investigation of Client #2's incident revealed the following recommendations: a. Provide training with staff regarding policy changes b. Provide additional training with staff regarding the client's oxygen protocol c. Implement recommendations from the emergency department. According to the PD/RN, the incident resulted in the revision in Client #2's oxygen protocol and the staff had been retrained. The review of training records provided on July 2, 2010 at 4:30 p.m. revealed the following information: June 21, 2010 - Training by the house manager. Agenda: Client 2's oxygen tank. Check - recheck air flow before removing the individual from the home. Make sure that white tab is visible (white tab means it can be used). No white tab means don't use. Place oxygen on the individual prior to leaving home. Review of the training roster signatures revealed	W 192		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G194	A. BUILDING _____ B. WING _____	07/02/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INNOVATIVE LIFE SOLUTIONS, INC	114 DIVISION AVENUE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 192	Continued From page 7 that 3 (S11, S3, and S7) of the 11 direct care staff currently on the schedule had not signed the roster to verify their attendance. There was no evidence that staff had participated in the training on June 21, 2010 or thereafter.	W 192		
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure continuous active treatment was implemented in accordance with the interdisciplinary team (IDT) recommendations for one of three clients in the sample. (Client 1) The finding includes: The facility failed to ensure a training objective identified in Client #1's individual program plan (IPP) was consistently implemented, as evidenced below: On June 30, 2010 at 9:15 a.m., Client #1 was observed seated at a table weaving a potholder on a frame. On the following morning (July 1, 2010) she was observed playing bingo at the same time.	W 249	W249 See W159.2	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G194	A. BUILDING _____ B. WING _____	07/02/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INNOVATIVE LIFE SOLUTIONS, INC	114 DIVISION AVENUE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 249	Continued From page 8 Interview with both Client #1 and the direct support staff on July 1, 2010, at 4:10 p.m., revealed that she enjoyed the aforementioned recreational activities. Staff also indicated that the client was also able to perform a number of tasks with minimal staff assistance. Record review on July 2, 2010 at 2:39 p.m. revealed the interdisciplinary team recommended training goal to improve Client #2's personal management. The objective stated, "Given verbal prompts, [Client] will fold her clothing on 70% of trials for six consecutive months." On July 2, 2010 at 3:05 p.m., the qualified mental retardation professional (QMRP) was interviewed regarding the client's progress in the objective. She was unable, however, to verify that the objective had been implemented during May 2010 and June 2010. The QMRP stated that no data was collected for those months on folding laundry. At the time of the survey, there was no evidence that Client #2 had been provided continuous active treatment as recommended, to improve her laundry skills.	W 249		
W 252	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that data was collected in the form and required frequency, for one of the three clients in the sample. (Client #3)	W 252	W252 ILS has modified its Records Management Policy and Procedures to ensure purged data is available and accessible within the residential facility during the recertification survey period. Program Director will provide training with management on updated policy and procedures on or before 08/03/2010. QMRP will provide training with staff regarding documentation of individual #3 alternative day program on or before 08/04/2010.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G194	A. BUILDING _____ B. WING _____	07/02/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INNOVATIVE LIFE SOLUTIONS, INC	114 DIVISION AVENUE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 252	Continued From page 9	W 252		

The finding includes:

Interview with the qualified mental retardation professional (QMRP) and the house manager (HM) on June 30, 2010, at approximately 10:00 a.m., revealed Client #3 was "going to his day program today" for the first time in two years. Further interview revealed Client #3 had an alternative day program schedule at home.

Review of Client #3's Individual Program Plan (IPP) dated July 31, 2009, on July 2, 2010, at approximately 1:30 p.m., revealed the following objectives:

1. Given verbal prompts, the client will read items for dinner from the menu book on 60% of the opportunity per session for six consecutive months.

2. Given verbal prompts, the client will check out books/magazines of his choice from the library weekly on 60% of the opportunities per sessions for six consecutive months.

3. Once a week, the client will go to the store to make a purchase of an item of his choice on 60 % of the trials for six consecutive months.

4. When presented with two choices of activities, the client will select and engage in one leisure activity once a week for 15 minutes each session for six consecutive months.

Continued review revealed documentation is required. Review of the data forms on July 1, 2010, at approximately 1:45 p.m., revealed no documentation after April 23, 2010. Interview

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G194	A. BUILDING _____ B. WING _____	07/02/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INNOVATIVE LIFE SOLUTIONS, INC	114 DIVISION AVENUE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 252	Continued From page 10 with the QMRP revealed the facility was unable to locate Client #3's IPP's documentation after April 23, 2010. There was no evidence that data had been collected in accordance with Client #3's alternative day program IPP.	W 252		
W 325	482.460(a)(3)(iii) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes routine screening laboratory examinations as determined necessary by the physician. This STANDARD is not met as evidenced by: Based on interview, and record review, the facility failed to provide routine laboratory testing as determined necessary by the physician, for one of three clients included in the sample. (Client #3) The finding includes: The facility failed to obtain laboratory studies as ordered by the Primary Care Physician (PCP). Review of Client #3's physician's order (PO) from June 2009 to June 2010 on June 30, 2010, at 2:30 PM, revealed an order for the client to have laboratory studies for CBC, CMP, and HGA1C every three months, Lipids every six months, and TSH every year. Record review at that time revealed the the CBC, CMP, HGA1C and Lipid profile values were dated February 9, 2009 and April 14, 2010. There were no laboratory results available in the client's record for a TSH study. Interview with the Registered Nurse (RN) on July	W 325	W325 ILS Program Director provided training to nursing staff on July 12, 2010 on implementation of physician orders and specialist recommendations. RN will complete quality assurance monitoring of individuals' medical records when completing quarterly nurse's note, to include but not be limited to, ensuring laboratory and radiology tests are followed per physician order, follow up appointments are scheduled or completed, and medications are available, accessible, and given as prescribed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G194	A. BUILDING _____ B. WING _____	07/02/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INNOVATIVE LIFE SOLUTIONS, INC	114 DIVISION AVENUE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 325	Continued From page 11 2, 2010, at approximately 2:30 PM, regarding the prescribed laboratory studies confirmed that they had not been completed as ordered. There was no evidence that timely laboratory studies were conducted as prescribed by the physician.	W 325		
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the provision of nursing services in accordance with the needs of one of three clients in the sample (Client #2) The finding includes: On June 30, 2010 at 5:55 p.m., Client #2 was observed with her hand over her mouth. She stated the dentist had done a root canal on one of her teeth that day. Record review on July 2, 2010 at 9:35 a.m. revealed on June 15, 2010, the dentist also had performed a root canal of Client #2's tooth #4. A prescription dated June 15, 2010, for Cleocin 150 mg #30, 1 tab TID was also included in the client's record. A nursing progress note dated June 15, 2010 (2:44 p.m.) revealed the medication was prescribed as an antibiotic to be administered after the dental procedure. Interview with the program manager on July 2, 2010 at 1:35 p.m. revealed that the medication order for the Cleocin had been faxed to the pharmacy on June 15, 2010, however, the	W 331	W331 See W325	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G194	A. BUILDING _____ B. WING _____	07/02/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INNOVATIVE LIFE SOLUTIONS, INC	114 DIVISION AVENUE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 331	Continued From page 12 medication was never received by the group home. According to the nurse, upon calling the pharmacy on July 1, 2010, she was informed that the pharmacy never received the faxed medication order for Cleocin for Client #2. At the time of the survey, there was no evidence the nurse had conducted timely follow-up to ensure that the client received the prescribed medication.	W 331		
W 356	483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure timely treatment services for the maintenance of dental health of one of three clients in the sample. (Client # 2) The finding includes: Interview with Client #2 on June 30, 2010 at 5:55 p.m. revealed she was "not so good." Further discussion with the client revealed that the dentist had performed a root canal on her tooth and that additional root canals were recommended. Record review on July 1, 2010 at 2:37 p.m., revealed the following information regarding the client's dental treatment services: (a) February 10, 2009 - Diagnosis: Stage 3 gum disease. Sealants to teeth #15 and #16 were recommended to be performed during the next	W 356	W356 During recertification survey period, individual #2 was receiving active treatment by Dentist as per recommended plan. Upon completion of root canal therapy, individual #2 will begin scaling treatment as recommended. Individual #2 final root canal therapy was on July 23, 2010. Her initial scaling treatment is scheduled for August 10, 2010.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G194	A. BUILDING _____ B. WING _____	07/02/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INNOVATIVE LIFE SOLUTIONS, INC	114 DIVISION AVENUE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 356	Continued From page 13 visit. (b) March 3, 2009 - Sealants were applied, however the dentist noted that he was unable to obtain a diagnostic study. Next visit recommended in 3 months. (c) August 5, 2009 - Dentist noted that client had urgent need to see a doctor whose passion is abscesses. (d) September 9, 2009 - Patient was not seen; call to reschedule. Addendum note on consult indicated that insurance issue was resolved. Next appointment: December 13, 2009. (e) December 9, 2009 - Root planing and scaling recommended. (f) April 13, 2010 - Comprehensive oral evaluation conducted. Prevident Varnish treatment. (g) April 28, 2010 - Appointment missed due to unfamiliar area; rescheduled for May 18, 2010. (h) May 18, 2010 - #3, #31, #8 - " Consultation and Panorex exam. Diagnosis: Generalized periodontal disease and decayed teeth. Recommendation: 4 quadrants scaling and 3 root canals. (i) June 15, 2010 - Reason for referral: F/u (follow-up) visit from May 18, 2010 - scaling and 3 root canals. Dentist noted "Root canal of #4. Needs 2 more root canals", however, failed to mention the scaling. (j) June 30, 2010 - Reason for referral: F/u from	W 356		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G194	A. BUILDING _____ B. WING _____	07/02/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INNOVATIVE LIFE SOLUTIONS, INC	114 DIVISION AVENUE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 356	Continued From page 14 June 15, 2010 to continue root canal therapy. Dentist noted, " Patient had root canal therapy on #31. Next appointment on July 23, 2010, for root canal therapy. At the time of the survey, however, there was no evidence Client #2 had received the dental scaling recommended to address her Stage 3 gum disease.	W 356		
W 362	483.460(j)(1) DRUG REGIMEN REVIEW A pharmacist with input from the interdisciplinary team must review the drug regimen of each client at least quarterly. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that drug regimen reviews were conducted at least quarterly for three of three clients in the sample. (Clients #1, #2, and #3) The findings include: Interview with the program manager/registered nurse on July 1, 2010 at 12:25 p.m., revealed the pharmacist should come to the facility every three months to conduct reviews of the clients' medications. Record review on July 1, 2010 at 1:17 p.m. revealed pharmacy reviews dated June 17, 2009, December 10, 2009, March 15, 2010, for Clients #1, #2 and #3. There was no evidence, however, that a drug regimen review was conducted during the six month period between June 17, 2009 and December 10, 2009. The facility failed to ensure medication regimens	W 362	W362 ILS will establish a pharmacy visit schedule to ensure accessibility to residential facility and individual records for drug regimen reviews. ILS will ensure nursing staff availability during scheduled review on or before 08/04/2010.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G194	A. BUILDING _____ B. WING _____	07/02/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INNOVATIVE LIFE SOLUTIONS, INC	114 DIVISION AVENUE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 362	Continued From page 15 reviews were conducted quarterly as required, to obtain relevant input from the pharmacist.	W 362		
W 368	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that all drugs were administered in compliance with the physician' s orders for one of three clients in the sample. (Client #2) The finding includes: [Cross refer to W331] Interview with Client #2 on June 30, 2010 at 5:55 p.m. revealed she had a root canal several weeks before the survey. Record review on July 1, 2010 at 9:35 a.m. confirmed Client #2 had a root canal of tooth #4 on June 15, 2010. A nursing progress noted dated June 15, 2010 (2:44 p.m.) revealed the dentist prescribed Cleocin 150 mg #30, 1 tab TID, which was approved by the primary care physician (PCP) to be administered to the client. On July 1, 2010 at 3:47 p.m. the review of the medication administration record, however, failed to document that the client had received any of this medication. Interview with the program manager/registered nurse revealed that her investigation concerning the medication on July 1, 2010 revealed that Client #2 did not receive any dosages of the Cleocin, which was prescribed on June 15, 2010. At the time of the survey, there was no evidence	W 368	W368 See W325	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G194	A. BUILDING _____ B. WING _____	07/02/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INNOVATIVE LIFE SOLUTIONS, INC	114 DIVISION AVENUE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 368	Continued From page 16 the facility ensured a system for the administration of each medication prescribed by the physician.	W 368		
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure adaptive equipment were being furnished, monitored and maintained as recommended, for one of three clients in the sample. (Client #3) The findings include: The facility staff failed to ensure consistent use of Client #3's eyeglasses. On June 30, 2010, at 2:30 p.m., review of Client #3's physician order, dated June 1, 2010, revealed an order for eyeglasses. On June 30, 2010, at 6:25 p.m., review of the client's ophthalmology consult form, dated May 3, 2010, revealed the client was prescribed eyeglasses for distance. On July 2, 2010, at 3:59 p.m., review of the health management care plan revealed the staff is required to provide and encourage Client #3 to wear his glasses as ordered. Interview with the qualified mental retardation professional (QMRP) and the registered nurse (RN) on July 2, 2010, at approximately 4:15 p.m., revealed Client	W 436	W436 Nursing will provide training with staff on individual #3 Health Maintenance Care Plan. This training will include appropriate documentation of encouragement and / or individual's refusal to wear glasses. Interdisciplinary team, including primary care physician and ophthalmologist, for individual #3 will discuss possible alternatives for impaired vision due to individual's consistent refusal to wear glasses on or before 08/04/2010.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G194	A. BUILDING _____ B. WING _____	07/02/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INNOVATIVE LIFE SOLUTIONS, INC	114 DIVISION AVENUE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 436	Continued From page 17 #3 had an order to wear glasses for distance. However, at no time during the survey period was the client observed wearing glasses or being encouraged to wear his glasses.	W 436		
W 440	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to hold evacuation drills at least quarterly for each shift of personnel, for one of the three shifts of duty reviewed. The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) and review of the staffing pattern on June 30, 2010, at 9:30 a.m. revealed the following staffing pattern: Sunday - Saturday 8:00 a.m. - 4:00 p.m.; 4:00 p.m.-12:00 p.m.; 12:00 p.m. - 8:00 a.m.; Monday-Friday 8:00 a.m. - 4:00 p.m.; 4:00 p.m.-12:00 p.m. and 12:00 p.m. - 8:00 a.m. Review of the fire drill log revealed that the weekend shift for 8:00 a.m.- 4:00 p.m., from June 2009 to June 2010, failed to hold evacuation drills per shift per quarter. There was no evidence that the facility held fire drills at least quarterly for each shift of personnel.	W 440	W440 QMRP will train Facility Coordinator on fire and evacuation drills. Facility Coordinator will conduct fire and evacuation drill per shift of personnel at least quarterly. QMRP will review fire drill log to ensure fire and evacuation drills are conducted for each shift of personnel at least quarterly and document this review in the QMRP Quarterly Note on or before 08/04/2010.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G194	A. BUILDING _____ B. WING _____	07/02/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INNOVATIVE LIFE SOLUTIONS, INC	114 DIVISION AVENUE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 455	483.470(I)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observation and interview the facility failed to ensure proper infection control procedures, for one of the three clients in the sample. (Client #1) The finding includes: On June 30, 2010, at 7:02 p.m., Client #1 arrived home from a medical appointment. Upon entering the facility the client sat at the dining room table. At 7:06 p.m., the direct support staff placed a plate of food in front of the client. Seconds later, the client was observed eating chicken, rice, corn and wheat bread. The client was not observed or asked to wash her hands prior to consuming her dinner. Interview with the qualified mental retardation professional (QMRP), on July 1, 2010, at approximately 3:30 p.m., revealed all clients are required to wash their hands before eating.	W 455	W455 QMRP and LPN Coordinator will train staff on Infection Control, to include frequent hand washing of individuals and staff to avoid spreading germs and preventing infections on or before 08/04/2010.	
W 482	483.480(d)(1) DINING AREAS AND SERVICE The facility must serve meals for all clients, including persons with ambulation deficits, in dining areas, unless otherwise specified by the interdisciplinary team or a physician. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to encourage one of three clients in the	W 482	W482 QMRP will review Individual Rights Policy with staff. ILS staff will continue to encourage milieu integration and socialization among individuals especially during activities and mealtimes. Staff will document individual's refusal to participate on or before 08/04/2010.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G194	A. BUILDING _____ B. WING _____	07/02/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INNOVATIVE LIFE SOLUTIONS, INC	114 DIVISION AVENUE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 482	Continued From page 19 sample to eat meals in the dining area. (Client #3) The finding include: On June 30, 2010 at 8: 17 a.m., a staff was observed bringing Client #3's empty dishes from his bedroom. Interview with staff at time revealed the client had requested to eat breakfast in bed. On June 30, 2010, at 5:15 p.m., Client #3 was observed eating dinner in bed. Subsequent interview with the direct support staff revealed the client refused to eat dinner at the table. Further observation revealed the head of his bed was partially raised as he ate his dinner. At the time of the survey, however, there was no evidence the direct support staff encouraged Client #3 to eat in the dining area. (See W159)	W 482		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0203	A. BUILDING _____ B. WING _____	07/02/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INNOVATIVE LIFE SOLUTIONS, INC	114 DIVISION AVENUE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 000	INITIAL COMMENTS A licensure survey was conducted from June 30, 2010, through July 2, 2010. A sampling of three residents was selected from a resident population of two men and three women with various degrees of intellectual and/or developmental disabilities. The findings of the survey were based on observations, interviews with residents and staff in the home and at two day programs, as well as a review of resident and administrative records, including incident reports.	I 000		
I 043	3502.2(c) MEAL SERVICE / DINING AREAS Modified diets shall be as follows: (c) Reviewed at least quarterly by a dietitian. This Statute is not met as evidenced by: Based on interview and record review, the Group Home for the Mentally Retarded (GHMRP) failed to ensure that modified diets were reviewed at least quarterly by a dietitian, for two of the three residents in the sample. (Residents #2 and #3) The findings includes: 1. On June 30, 2010 at 8:20 a.m., Resident #2 was observed drinking a Breeze liquid nutritional supplement. On June 30, 2010, at 8:32 a.m., staff stated that Resident #2 received an 8 oz serving of Resource Breeze liquid nutritional supplement twice daily. On July 1 2010, the record review beginning at 1:35 p.m., revealed the resident's nutrition records and physician's orders (POs) confirmed	I 043	I043 The QMRP responsible for maintaining individuals' records during the time period October 2009 and April 2010 is no longer employed with ILS. The current QMRP contacted the nutritionist to obtain copies of quarterly assessments completed October 2009 and January 2010. At the time of the recertification survey, the nutritionist was out of town and unable to send quarterly reports via email as requested. The nutritionist confirmed that the assessments were completed and previously sent to the former QMRP. QMRP will ensure documentation is obtained and filed in individual #2 and #3 records.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0203	A. BUILDING _____ B. WING _____	07/02/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INNOVATIVE LIFE SOLUTIONS, INC	114 DIVISION AVENUE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 043	Continued From page 1 the client was prescribed a regular, no added salt, low fat, low cholesterol diet, with Resource Breeze 2 times a day. Additionally, the review of Resident #2's nutrition records revealed that the consulting nutritionist had assessed her dietary needs on October 30, 2009 and April 30, 2010. On July 2, 2010 at approximately 3:30 p.m., the administrator was informed that the quarterly review due between October 2009 and April 2010 was not available. He indicated that the nutritionist was usually diligent to ensure that reviews were conducted timely. At the time of the survey, however, there was no documented evidence that a nutritionist/dietitian had reviewed Resident #2's diet at least quarterly. 3. On June 30, 2010, at 5:15 p.m., Resident #3 was observed eating chopped chicken, rice and corn in a high sided plate with a built up spoon in a palm cuff. Review of Resident #3's nutritional assessment dated July 30, 2009 on June 30, 2010, at 6:10 p.m., revealed that the resident was prescribed a chopped 1800-1950 diet. Further review failed to show evidence that the facility's nutritionist had reviewed Resident #3's diet on a quarterly basis. On July 2, 2010, at approximately 3:15 p.m., interview with the qualified mental retardation professional confirmed that there was no evidence that a first and second quarterly nutrition reviews were conducted. At the time of the survey, the GHMRP failed to have a nutrition review for the first and second quarter.	I 043		
I 090	3504.1 HOUSEKEEPING	I 090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0203	A. BUILDING _____ B. WING _____	07/02/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INNOVATIVE LIFE SOLUTIONS, INC	114 DIVISION AVENUE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 090	Continued From page 2 The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observation and interview, and record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure the exterior of the GHMRP was maintained in a safe and attractive manner for five of the five residents. (Residents #1, #2, #3, #4, and #5) The findings include: During the inspection of the exterior environment on June 30, 2010, beginning at 1:45 p.m., the following concerns were identified: a. There was an accumulation of leaves, lint, and trash in the covered window wells located outside the laundry room. b. The metal cover over the drain located at the basement entrance door was broken, causing a wide space between the metal openings. c. Plastic bins were observed stacked on top of each other in the storage shed at located at the rear of the facility. Closer observation of the bins revealed the lids of the bins at the bottom of the stack were crushed and the sides of the bins were cracked open,causing the contents to be visible. Interview with the facility manager revealed some of the bins contained the residents' seasonal clothing. At the time of the survey, there was no	I 090	I090 On July 1, 2010, all environmental concerns were addressed and corrected. ILS will ensure maintenance contractor provides monthly monitoring of residential facility interior and exterior environment.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0203	A. BUILDING _____ B. WING _____	07/02/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INNOVATIVE LIFE SOLUTIONS, INC	114 DIVISION AVENUE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 090	Continued From page 3 evidence the facility had ensured the clients' clothing had been securely stored. d. Trash was observed in the gutter at the rear of the house. e. Old furniture was on the ground near the trash cans in the back yard. Interview with the facility manager revealed that an appointment had been scheduled with bulky trash to have the items removed from the premises, however, the pick-up had not been completed as scheduled.	I 090		
I 135	3505.5 FIRE SAFETY Each GHMRP shall conduct simulated fire drills in order to test the effectiveness of the plan at least four (4) times a year for each shift. This Statute is not met as evidenced by: Based on staff interview and record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to conduct simulated fire drills in order to test the effectiveness of the plan at least four times a year for each shift, for five of five residents residing in the GHMRP. (Residents #1, #2, #3 , #4 and #5) The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) and review of the staffing pattern on June 30, 2010, at 9:30 a.m., revealed the following staffing pattern: Sunday - Saturday 8:00 a.m. - 4:00 p.m.;	I 135	I135 See W440	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0203	A. BUILDING _____ B. WING _____	07/02/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INNOVATIVE LIFE SOLUTIONS, INC	114 DIVISION AVENUE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 135	Continued From page 4 4:00 p.m.-12:00 p.m.; 12:00 p.m. - 8:00 a.m.; Monday - Friday 8:00 a.m. - 4:00 p.m.; 4:00 p.m. -12:00 p.m. and 12:00 p.m. - 8:00 a.m. Review of the fire drill log revealed that from June 2009 to June 2010, the weekend shift for 8:00 a.m.- 4:00 p.m., failed to hold evacuation drills per shift per quarter. There was no evidence that the GHMRP held fire drills at least quarterly for each shift of personnel.	I 135		
I 180	3508.1 ADMINISTRATIVE SUPPORT Each GHMRP shall provide adequate administrative support to efficiently meet the needs of the residents as required by their Habilitation plans. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure the Qualified Mental Retardation Professional (QMRP) coordinated, integrated, and monitored services, for two off three residents in the sample. (Residents #1 and #3) The finding includes: 1. The GHMRP's QMRP failed to coordinate services with the speech pathologist to ensure staff was effectively trained on how to properly position Resident #3's bed as he ate in bed. On June 30, 2010, at 5:15 p.m., Resident #3 was observed eating dinner in bed. Subsequent interview with the direct support staff revealed the	I 180	I180 1. See W159.1 2. See W159.2 3. See W159.3	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0203	A. BUILDING _____ B. WING _____	07/02/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INNOVATIVE LIFE SOLUTIONS, INC	114 DIVISION AVENUE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 180	Continued From page 5 resident refused to have dinner at the table. Further observation revealed the head of his bed was partially raised as he ate his dinner. Review of Resident #3 's Speech mealtime guidelines dated August 10, 2008, on June 30, 2010, at 7:30 p.m. revealed staff is required to have the resident seated in an upright position to the maximum degree possible when eating in bed. Interview with the administrator on July 1, 2010, at 2:50 p.m., indicated that Resident #3's bed should not be positioned at the maximum degree while eating in bed. Further interview with the administrator and the QMRP revealed they will request a comprehensive assessment from the speech pathologist. At the time of the survey, there was no evidence that the QMRP had coordinated with the Interdisciplinary Team (IDT), including the speech pathologist to determine if the previous recommendations in the protocol continued to be appropriate for the resident. 2. The GHMRP's QMRP failed to ensure continuous active treatment for Resident #2 on her training objective designed to improve her personal management skills (folding of clothing). [See W249] 3. The GHMRP's QMRP failed to coordinate the physical therapy recommendation that Resident #3 be provided a headrest for his wheelchair. On June 30, 2010, at 6:31 p.m., review of Resident #3's physical therapy wheelchair evaluation form, dated June 16, 2010, revealed a recommendation to install two footrest on the resident's wheelchair and a headrest to "support his head". Interview with the house manager (HM) and the QMRP on July 2, 2010, revealed	I 180		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0203	A. BUILDING _____ B. WING _____	07/02/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INNOVATIVE LIFE SOLUTIONS, INC	114 DIVISION AVENUE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 180	Continued From page 6 that the resident's footrests were ordered, however, the facility was unaware of the recommendation for a headrest.	I 180		
I 222	3510.3 STAFF TRAINING There shall be continuous, ongoing in-service training programs scheduled for all personnel. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure continuing training program for all personnel to address the needs of two of three residents in the sample. (Residents #2 and #3) The findings include: I. The facility failed to ensure staff demonstrated competency in implementing Resident #3's diet order, as evidenced below: On June 30, 2010, at 11:49 a.m., Resident #3's one to one direct support staff from the facility, informed the day program cafeteria staff of Resident #3's diet. At 12:24 p.m., Resident #3 was observed eating tuna salad, garden salad, and peaches with an built handled spoon. At 12:28 p.m., the resident asked the one to one staff to assist him with picking up his crackers. The one to one staff picked up the whole cracker and placed it on the resident's spoon. The resident then placed the whole cracker in his mouth. Review of Resident #1's physician orders (POS) dated June 1, 2010, on June 30, 2010, at 2:30 p.m., revealed Resident #3 was on a chopped, high fiber, no concentrated sweets diet. Additional review revealed an order for the resident to	I 222	I222 1. See W189 2. See W192	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0203	A. BUILDING _____ B. WING _____	07/02/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INNOVATIVE LIFE SOLUTIONS, INC	114 DIVISION AVENUE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 222	Continued From page 7 receive a low fat, low calorie yogurt at breakfast and lunch. Interview with the one to one staff on the same day, at 4:40 p.m., confirmed Resident #3 did not receive yogurt for lunch. Further interview revealed the resident's crackers was not chopped as ordered. There was no evidence that the facility implemented Resident #3's diet as ordered. 2. The facility failed to ensure that each staff received updated training on Resident #2's protocol for the continuous administration of oxygen, as evidenced below: On June 30, 2010 at 8:58 a.m., Resident #2 was observed leaving the facility with portable oxygen infusing via a nasal cannula. Interview with staff at this time revealed the resident was going to an appointment and that she always must take her oxygen with her. The review of unusual incidents on June 30, 2010 at 1:40 p.m., revealed on June 21, 2010, Resident #2 ran out of oxygen while on her way to an audiology appointment. Interview with the van driver on July 2, 2010 at 9:15 a.m., and the van escort at 2:37 p.m. revealed that they checked the gauge on Resident #2's oxygen tank on June 21, 2010 prior to putting her on the van. Both staff indicated that the gauge was in " the green", which indicated the resident still had oxygen in the tank. The driver revealed that the resident rode with her and the van escort to drop off her house mate at her day program. They then proceeded to Resident #2's audiology appointment at a local hospital. According to both staff, approximately one block from the appointment, the resident indicated that she having breathing difficulty. Upon checking	I 222		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0203	A. BUILDING _____ B. WING _____	07/02/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INNOVATIVE LIFE SOLUTIONS, INC	114 DIVISION AVENUE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 222	Continued From page 8 the gauge on the oxygen tank, they noted that the gauge was in "the red", which indicated there was no more oxygen available. After notifying the home for further instructions, an attempt was made by the staff to obtain oxygen from the audio clinic, however she was told there was none. The staff indicated that they then attempted to return to the home to get oxygen as instructed, however a few minutes later, the resident stated that her "arm hurt". Emergency Medical Services (EMS) was called, and upon arrival provided oxygen, then transported the resident to the emergency room, when she was further assessed. The Resident was discharged to the group home on the same day in stable condition. On July 2, 2010 at 3:07 p.m., the review of the investigation of the incident revealed it concluded that "the gauge on the oxygen tank used to verify the level of oxygen may have malfunctioned, causing staff and the individual to see a false reading of the amount of available oxygen in the tank." Record review on July 2, 2010 at 3:17 p.m. revealed on 3/4/10, the pulmonologist stated "Patient's oxygen saturation is 68% after only 2 minutes of hallway walking. Provide continuous therapy at all times." Interview with the program director (PD)/Registered Nurse (RN) on July 2, 2010 at 10:15 a.m., revealed the resident is now to take a large oxygen tank and also a small oxygen tank with her daily, when leaving the facility. The PD/RN indicated that the pharmacy had started sending the 4 unit oxygen tanks instead of the 6 unit ones previously provided to the resident, however, had not informed the home of this change. The PD/RN stated that the agency policy was adjusted to state that the resident is to have an additional 2 hour portable oxygen tank when escorted out of the residential facility for any	I 222		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0203	A. BUILDING _____ B. WING _____	07/02/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INNOVATIVE LIFE SOLUTIONS, INC	114 DIVISION AVENUE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 222	Continued From page 9 reason. Further review of the agency's investigation of Resident #2's incident revealed the following recommendations: a. Provide training with staff regarding policy changes b. Provide additional training with staff regarding the resident's oxygen protocol c. Implement recommendations from the emergency department. According to the PD/RN, the incident resulted in the revision in Resident #2's oxygen protocol and the staff had been retrained. The review of training records provided on July 2, 2010 at 4:30 p.m. revealed the following information: a. June 21, 2010 - Training by the house manager. Agenda: Resident 2's oxygen tank. Check - recheck air flow before removing the individual from the home. Make sure that white tab is visible (white tab means it can be used). No white tab means don't use. Place oxygen on the individual prior to leaving home. Review of the training roster signatures revealed that 3 (S11, S3, and S7) of the 11 direct care staff currently on the schedule had not signed the roster to verify their attendance. There was no evidence that Staff had participated in the training on June 21, 2010 or thereafter. b. The program director was also requested to provide the roster of the individuals in attendance at the last training prior to the 6/21/10 incident. The provided training were dated January 26, 2009 and January 27, 2009. The review of these rosters revealed the name of one direct support staff currently working at the facility was included. At the time of the survey, the facility failed to provide evidence that each staff working at the group home had received training on Resident #2's oxygen protocol.	I 222		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0203	A. BUILDING _____ B. WING _____	07/02/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INNOVATIVE LIFE SOLUTIONS, INC	114 DIVISION AVENUE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 399	3520.2(i) PROFESSION SERVICES: GENERAL PROVISIONS Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services: (i) Speech and language therapy; and... This Statute is not met as evidenced by: Based on interview and record review, the Group Home for Persons with Mental Retardation (GHMRP) failed to ensure that a copy of professional credentials was maintained for each individual providing professional services at the GHMRP, as required by District of Columbia law, in the following disciplines or area: (i) Speech and Language Therapy. The finding includes: Review of the personnel records on June 30, 2010, beginning at 5:30 p.m., revealed that a current license was not available for the Speech Language Therapist. On July 1, 2010 a approximately 4:15 p.m., the program director indicated that she would follow-up with the administrative office to determine if a professional licensure was available for the Speech Language Therapist providing direct services for the group home. On	I 399	I399 ILS will maintain current professional services licenses for all providers. ILS will obtain current license for Speech and Language Therapist.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0203	A. BUILDING _____ B. WING _____	07/02/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INNOVATIVE LIFE SOLUTIONS, INC	114 DIVISION AVENUE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 399	Continued From page 11 July 2, 2010 at 4:15 p.m., the administrator revealed that no professional licensure had been provided to the agency by the Speech Language Therapist. On July 6, 2010, at beginning at 9:42 a.m., a post-survey search of professional licensing records online revealed no evidence that the consulting Speech Language Therapist was licensed to practice in the District of Columbia, in accordance with: Title 3, Chapter 12 of the District of Columbia Official Code SUBCHAPTER V. LICENSING, REGISTRATION, OR CERTIFICATION OF HEALTH PROFESSIONALS § 3-1205.01. License, registration, or certification required. (a) A license issued pursuant to this chapter is required to practice medicine, acupuncture, chiropractic, registered nursing, practical nursing, dentistry, dental hygiene, dietetics, marriage and family therapy, massage therapy, naturopathic medicine, nutrition, nursing home administration, occupational therapy, optometry, pharmaceutical detailing, pharmacy, physical therapy, podiatry, psychology, social work, professional counseling, audiology, speech-language pathology, respiratory care, advanced practice addiction counseling, or to practice as an anesthesiologist assistant, physician assistant, physical therapy assistant, polysomnographic technologist, occupational therapy assistant, or surgical assistant in the District, except as otherwise provided in this chapter.	I 399		
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis	I 401		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0203	A. BUILDING _____ B. WING _____	07/02/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INNOVATIVE LIFE SOLUTIONS, INC	114 DIVISION AVENUE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 401	Continued From page 12 and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on observation, interview and record review, the group home for mentally retarded persons (GHMRP) failed to ensure professional services were provided in accordance with the needs of three of three residents in the sample. (Residents #1, #2, and #3) The findings include: 1. The GHMRP failed to obtain laboratory studies as ordered by the Primary Care Physician (PCP), for Resident #3. Review of Resident #3's physician's order (PO) from June 2009 to June 2010 on June 30, 2010, at 2:30 PM, revealed an order for the resident to have laboratory studies for CBC, CMP, and HGA1C every three months, Lipids every six months, and TSH every year. Record review at that time revealed the the CBC, CMP, HGA1C and Lipid profile values were dated February 9, 2009 and April 14, 2010. There were no laboratory results available in the resident's record for a TSH study. Interview with the Registered Nurse (RN) on July 2, 2010, at approximately 2:30 PM, regarding the prescribed laboratory studies confirmed that they had not been completed as ordered. There was no evidence that timely laboratory studies were conducted as prescribed by the physician.	I 401	I401 1. See W325 2. See W325 3. See W356 4. See W362	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0203	A. BUILDING _____ B. WING _____	07/02/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INNOVATIVE LIFE SOLUTIONS, INC	114 DIVISION AVENUE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 401	Continued From page 13 2. The GHMRP failed to ensure the provision of nursing services in accordance with the needs of one of three residents in the sample (Resident #2) On June 30, 2010 at 5:55 p.m., Resident #2 was observed with her hand over her mouth. She stated the dentist had done a root canal on one of her teeth that day. Record review on July 2, 2010 at 9:35 a.m. revealed on June 15, 2010, the dentist also had performed a root canal of Resident #2's tooth #4. A prescription dated June 15, 2010, for Cleocin 150 mg #30, 1 tab TID was also included in the resident's record. A nursing progress note dated June 15, 2010 (2:44 p.m.) revealed the medication was prescribed as an antibiotic to be administered after the dental procedure. Interview with the program manager on July 2, 2010 at 1:35 p.m. revealed that the medication order for the Cleocin had been faxed to the pharmacy on June 15, 2010, however, the medication was never received by the group home. According to the nurse, upon calling the pharmacy on July 1, 2010, she was informed that the pharmacy never received the faxed medication order for Cleocin for Resident #2. At the time of the survey, there was no evidence the nurse had conducted timely follow-up to ensure that the resident received the prescribed medication. 3. The GHMRP failed to ensure timely treatment services for the maintenance of dental health of one of three residents in the sample. (Resident # 2) Interview with Resident #2 on June 30, 2010 at 5:55 p.m. revealed she was "not so good."	I 401		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0203	A. BUILDING _____ B. WING _____	07/02/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INNOVATIVE LIFE SOLUTIONS, INC	114 DIVISION AVENUE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 401	Continued From page 14 Further discussion with the resident revealed that the dentist had performed a root canal on her tooth and that additional root canals were recommended. Record review on July 1, 2010 at 2:37 p.m., revealed the following information regarding the resident's dental treatment services: (a) February 10, 2009 - Diagnosis: Stage 3 gum disease. Sealants to teeth #15 and #16 were recommended to be performed during the next visit. (b) March 3, 2009 - Sealants were applied, however the dentist noted that he was unable to obtain a diagnostic study. Next visit recommended in 3 months. (c) August 5, 2009 - Dentist noted that resident had urgent need to see a doctor whose passion is abscesses. (d) September 9, 2009 - Patient was not seen; call to reschedule. Addendum note on consult indicated that insurance issue was resolved. Next appointment: December 13, 2009. (e) December 9, 2009 - Root planing and scaling recommended. (f) April 13, 2010 - Comprehensive oral evaluation conducted. Prevident Varnish treatment (g) April 28, 2010 - Appointment missed due to unfamiliar area; rescheduled for May 18, 2010. (h) May 18, 2010 - #3, #31, #8 - " Consultation and Panorex exam. Diagnosis: Generalized	I 401		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0203	A. BUILDING _____ B. WING _____	07/02/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INNOVATIVE LIFE SOLUTIONS, INC	114 DIVISION AVENUE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 401	Continued From page 15 periodontal disease and decayed teeth. Recommendation: 4 quadrants scaling and 3 root canals. (i) June 15, 2010 - Reason for referral: F/u (follow-up) visit from May 18, 2010 - scaling and 3 root canals. Dentist noted " Root canal of #4. Needs 2 more root canals ", however, failed to mention the scaling. (j) June 30, 2010 - Reason for referral: F/u from June 15, 2010 to continue root canal therapy. Dentist noted, " Patient had root canal therapy on #31. Next appointment on July 23, 2010, for root canal therapy. At the time of the survey, however, there was no evidence Resident #2 had received the dental scaling recommended to address her Stage 3 gum disease. 4. The GHMRP failed to ensure that drug regimen reviews were conducted at least quarterly for three of three residents in the sample. (Residents #1, #2, and #3) Interview with the program manager/registered nurse on July 1, 2010 at 12:25 p.m., revealed the pharmacist should come to the GHMRP every three months to conduct reviews of the residents' medications. Record review on July 1, 2010 at 1:17 p.m. revealed pharmacy reviews dated June 17, 2009, December 10, 2009, March 15, 2010, for Residents #1, #2 and #3. There was no evidence, however, that a drug regimen review was conducted during the six month period between June 17, 2009 and December 10, 2009.	I 401		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0203	A. BUILDING _____ B. WING _____	07/02/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INNOVATIVE LIFE SOLUTIONS, INC	114 DIVISION AVENUE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 401	Continued From page 16 The GHMRP failed to ensure medication regimens reviews were conducted quarterly as required, to obtain relevant input from the pharmacist.	I 401		
I 405	3520.7 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall be provided by programs operated by the GHMRP or personnel employed by the GHMRP or by arrangements between the GHMRP and other service providers, including both public and private agencies and individual practitioners. This Statute is not met as evidenced by: Based on observation, interview and record review, the Group Home for the Mentally Retarded Persons (GHMRP) failed to ensure professional services had been provided in accordance with each resident's needs, for one of the three residents included in the sample. (Resident #3) The finding includes: On June 30, 2010, beginning at 11:34 a.m., Resident #3 was observed watching a concert on television at his day program. At 11:50 a.m., he was observed sitting in a different class room with his one to one direct support staff and classmates. Interview with the one to one staff revealed they were waiting for lunch to be serve. At 12:21 p.m., Resident #3 went into the cafeteria to have lunch. On June 30, 2010, at 2:30 p.m., review of Resident #3's physician order dated, June 1, 2010, revealed an order stating "elevate legs while client is in wheelchair." At no time during	I 405	I405 See W120	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0203	A. BUILDING _____ B. WING _____	07/02/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INNOVATIVE LIFE SOLUTIONS, INC	114 DIVISION AVENUE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 405	Continued From page 17 the survey at the day program did resident #3 have his legs elevated. Interview with the one to one staff on the same day, at 4:40 p.m., confirmed that client #3 did not elevate his legs while at the day program. The GHMRP failed to ensure that the day program encouraged Resident #3 to elevate his legs as prescribed.	I 405		